FAMILY CHILD CARE PROVIDER
HEALTH ASSESSMENT

CERTIFICATE OF MEDICAL EXAMINATION	(Applicant must supply information below to heavy line) Typewrite or Print in Ink	For use of this form, see AR 608-10; the Proponent agency is Child Development Services.

1. Name (CAPS) LAST – FIRST -- MIDDLE	2. SEX ( ) MALE ( ) FEMALE	3. BIRTH DATE (*mo., day, year*)	4. SOCIAL SECURITY NUMBER

5. STREET ADDRESS AND APARTMENT NUMBER	6. CITY, STATE, AND ZIP CODE

7. (A) HAVE YOU ANY PHYSICAL DEFECT OR DISABILITY? ( ) YES ( ) NO IF "YES", GIVE DETAILS.

Sign your name in INK as it appears on your application in the presence of The examiner for purpose of identification.	SIGNATURE OF APPLICANT

DOCTOR: All questions on both sides of this certificate and on the lower half of the attached Health Qualification Placement Record must be answered. Before beginning the examination, refer to item 8 on the Health qualification Placement Record so that you will have knowledge of the physical requirements of the position to which the applicant is to be appointed. Sign both this certificate and the Health qualification Placement Record.

1. HEIGHT: _____ **FEET** _____ **INCHES** **WEIGHT:** _____ **POUNDS**

2. EYES: 20 20 20 20.

(A) DISTANT VISION (Snellen): WITHOUT GLASSES: RIGHT LEFT WITH GLASSES, IF WORN: RIGHT LE FT

(C) EVIDENCE OF DISEASE OR INJURY: RIGHT _____ LEFT _____

(D) COLOR VISION: IS COLOR VISION NORMAL WHEN ISHIHARA OR OTHER COLOR PLATE TEST IS USED: ___ YES ___ NO

IF NOT, CAN APPLICANT PASS LANTERN, YARN, OR OTHER COMPARABLE TEST? ___YES ___NO

3. EARS: (CONSIDER DENOMINATORS INDICATED HERE AS NORMAL. RECORD AS NUMERATORS THE GREATEST DISTANCE HEARD)
ORDINARY CONVERSATION:
RIGHT EAR ____ 20 FT. LEFT EAR ____ 20 FT. EVIDENCE OF DISEASE OR INJURY: RIGHT EAR _____ LEFT EAR _____

4. NOSE	5. MOUTH AND THROAT	6. ABDOMEN

7 ARE YOU UNDER TREATMENT OR EVER BEEN DIAGNOSED WITH ANY MEDICAL CONDITION? (IF "YES" LIST CONDITION AND MEDICATION TAKEN)

9. CARDIOVASCULAR

VITALS

(A) BLOOD PRESSURE:

SYSTOLIC _____

MM. HG.

DIASTOLIC _____

(B) PULSE RATE:

10. LUNGS:

RIGHT _____ LEFT _____

HISTORY OF TUBERCULOSIS? ( ) YES ( ) NO IF "YES", HOW LONG HAS THE DISEASE BEEN ARRESTED?

IF THERE IS HISTORY OF TUBERCULOSIS, IS ANY TYPE OF COLLAPSE THERAPY BEING RECEIVED AT PRESENT? ( ) YES ( ) NO
IF "YES", GIVE FULL DETAILS UNDER "REMARKS". IS MEDICAL SUPERVISION NECESSARY? ( ) YES ( ) NO

(IF X-RAY IS MADE, GIVE REPORT UNDER "REMARKS.")

11. HERNIA: ( ) YES ( ) NO IF "YES", NAME VARIETY: INGUINAL, VENTRAL, FEMORAL, POST-OPERATIVE, ETC.

IF PRESENT, IS IT SUPPORTED BY A WELL-FITTING TRUSS? ( ) YES ( ) NO

12. MUSCULOSKELETAL

(A) BACK

(B) EXTREMETIES

13. SCARS OF SERIOUS INJURY OR DISEASE?

14. DEFORMITIES, ATROPHIES, AND OTHER ABNORMALITIES, DISEASE NOT INCLUDED ABOVE:

15. NERVOUS SYSTEM: INCLUDE SYMPTOMS AND FULL HISTORY OF ANY MENTAL, NERVOUS OR EMOTIONAL ABNORMALITY (USE ADDITIONAL SHEET IF NECESSARY):

(A) HAS APPLICANT EVER BEEN HOSPITALIZED OR TREATED FOR A MENTAL ILLNESS? ( ) YES ( ) NO

(B) WHERE (NAME, LOCATION OF HOSPITAL): _____

(C) DATE(S) OF HOSPITALIZATION: _____

(D) DESCRIBE ANY RESIDUALS OF PREVIOUS MENTAL OR NERVOUS ILLNESS _____

_____

(E) ANY HISTORY OF EPILEPSY OR FAINTING SPELLS? ( ) YES ( ) NO IF "YES", GIVE DETAILS UNDER "REMARKS " BELOW.

16. EVIDENCE OR HISTORY OF VENEREAL DISEASE: IF BLOOD SEROLOGY OR OTHER LABORATORY EXAMINATIONS ARE MADE, GIVE DETAILS UNDER "REMARKS".

17. URINALYSIS (IF INDICATED):

SP. GR _____ ALBUMEN _____ SUGAR _____

CASTS _____ BLOOD _____ PUS _____

HAVE FOUND THE APPLICANT ABNORMAL UNDER THE FOLLOWING HEADINGS:

REMARKS

18. SIGNATURE OF PHYSICIAN OR EXAMINER	TYPED OR PRINTED NAME	DATE

19. ADDRESS OF EXAMINING PHYSICIAN *(Typed or printed)*	20. DO YOU HAVE FEDERAL DESIGNATION? ( )YES ( ) NO IF "YES", SPECIFY _____ ( ) FULL TIME ( ) PART TIME ( ) FEE BASIS

HEALTH QUALIFICATION PLACEMENT RECORD
FAMILY CHILD CARE

1. NAME (CAPS) LAST—FIRST—MIDDLE	2. SEX ( ) MALE ( )FEMALE	3. BIRTH DATE	4. SOCIAL SECURITY NUMBER

5. STREET ADDRESS AND APARTMENT NUMBER	6. CITY, STATE, AND ZIP CODE

7. IMMUNIZATIONS: **DATE:** _____

PPD _____

RUBELLA _____

RUBEOLA _____

_____**PHYSICALLY QUALIFIED**

_____**PHYSICALLY NOT QUALIFIED**

TO BE COMPLETED BY EXAMINING PHYSICIAN: SECTIONS 8 THOUGH 13

INSTRUCTIONS: The items below indicate the physical requirements of the position for which this individual is being considered. Indicate the individual's physical capacities for this position by placing an X in the appropriate column opposite the item. If the individual has any other physical limitations relating to physical requirements not covered by this form, indicate these under "Remarks" on the reverse side. Whenever PARTIAL capacity has been indicated, explain under "Remarks," giving specific quantities.

8. PHYSICAL REQUIREMENTS — ENVIRONMENTAL FACTORS

	CAPACITY				CAPACITY		
	FULL	PARTIAL	NONE		FULL	PARTIAL	NONE
1. OUTSIDE AND INSIDE				11. PUSHING (1 HOUR)			
2. DUST				12. REACHING ABOVE SHOULDERS			
3. MOVING OBJECTS OR VEHICLES				13. USE OF FINGERS			
4. UNUSUAL FATIGUE FACTORS *(specify)* (1-11 HOURS) CARING FOR CHILDREN 4 WKS – 12 YRS				14. SPECIFIC VISUAL REQUIREMENTS *(specify)* NEAR/FAR VISION 20/30			
5. WORKING WITH HANDS IN WATER.				15. WALKING (1-11 HOURS)			
6. WORKING CLOSELY WITH OTHERS				16. STANDING (1-11 HOURS)			
7. WORKS ALONE				17. KNEELING (1-11 HOURS)			
8. PROTRACTED OR IRREGULAR HOURS OF WORK				18. REPEATED BENDING (1-11 HOURS)			
9. MODERATE LIFTING (15-44 POUNDS)				19. BOTH LEGS REQUIRED			
10. MODERATE CARRYING (15-44 POUNDS)				20. BOTH HANDS REQUIRED			
				21. HEARING (AID PERMMITED)			

9. THIS PERSON SHOULD USE: (A) PROPERLY FITTED EYGLASSES _____ (B) PROPERLY FITTED HEARING AID _____
(C) OTHER PROSTHETIC AID *(Specify)*

10. REMARKS AND RECOMMENDATIONS

11. PHYSICAL HANDICAP CODE

12. SIGNATURE OF OCCUPATIONAL HEALTH EXAMINER	NAME (TYPED OR PRINTED)	DATE

13. SIGNATURE OF PHYSICIAN	NAME (TYPED OR PRINTED)	DATE

RETURN TO FAMILY CHILD CARE